opinion that though many authorities describe the organ as being curled upon itself that the curling of the organ is due to adhesions and the formation of constriction bands as the result of inflammatory processes. Briefly notes the manner of classifying different inflammatory processes of the appendix. Calls particular attention to the fact that the same etiological conditions may be found here as elsewhere in the body with the same causal agents. More frequently here than elsewhere, due to the proximity of the intestinal canal; the infecting agent is b. coli comunis, and most infections arise from the mucous lining. The appendix being a blind sack, when inflammatory processes arise within it tumefaction at the proximal end closes its only outlet. Then, by the accumulation of pus and serum the sack is distended and goes on to rupture or gangrene with localized peritonitis which may become diffuse or by the adhesion of adjacent portions of the peritoneum may form a walled-in abscess. This train of events has given two methods of treatment: Immediate operation to prevent rupture and peritonitis or: Expectant to allow time for the formation of a walled-in abscess.

There is a classical symptom complex for appendicitis but to obtain results one cannot wait for this classical picture to make a diagnosis for any one or more of these symptoms may be lacking. A sudden decrease in temperature with a rise in the pulse rate and a cessation of the subjective symptoms must be treated with suspicion. Medical treatment consists in rest and the application of heat or cold applications. Ice if the temperature is high and heat if there is much pain. Dr. McAulay does not know any reason why water should be withheld and rather encourages its use. Advises the use of castor oil repeated as frequently as necessary, using also high enemata of saline solution, soapsuds, milk and molasses or epsom salts three times daily. With frequent enemata, patients who have been very constipated will pass large masses of feces, followed by quantities of scybala and finally mucus and pus. Prefers operation in every case, because a positive diagnosis of the condition of the appendix can be made only by seeing the organ itself. In case of ruptured appendix the Mayos recommend doing all that is possible in ten minutes and completing at a subsequent operation, thus saving the patient from the effects of a long continued anesthetic. Dr. McAulay does not agree with this method of procedure, except when the patient is in extremis. She prefers to remove all that is offending at the first operation. The doctor recommends Dr. O'Brien's method of carefully sponging out the abscess cavity, disturbing the surrounding structures as little as possible, by slowly and carefully inserting sponges on long sponge holders until the bottom of the cavity is reached and the diseased area exposed for operative procedure. On first opening the abscess the walled-in pus is allowed to well out until a clear field is left for further procedure. Finally closing the wound leaving a drain which reaches to the bottom of the cavity.

Prognosis: There are no statistics offered for unoperated cases while less than 1% recover with late operation. The deaths result from both delay and sepsis. Out of 25 cases operated Dr. McAulay reports no deaths.

"Operation is simple and safe in uncomplicated cases, convalescence is short and cure certain, while after the appendix has ruptured the patient is not in condition for an easy operation or a long convalescence."

3. Operative Technique (in conjunction with Dr. McAulay's paper). Dr. J. T. O'Brien.

The classical gridiron incision is ideal when we are positive there is no pus. But this route gives room for only two fingers to enter and insufficient room in which to operate. So it is often necessary to extend the incision into the sheath of the rectus, often finding the epigastric artery in the way. As a consequence he prefers an oblique incision through the linea semilunaris. The gridiron incision, after the operation allows the tissues to resume their normal positions and relations, even being proof against injury during post operative vomiting, but is at the same time a hindrance to easy drainage. If the semilunar line cannot be found there is no harm done by going through the right rectus itself, provided the two layers of fascia are found and secured upon sewing up the abdomen.

The treatment of the appendix must depend upon the condition in which it is found. If ready to rupture clamp it with two clamps and cut between, always carefully ligating the mesoappendix. Treat the stump with carbolic acid and return the cecum to the peritoneal cavity. If there is time a purse string suture may be drawn about the base of the appendix, but this is not essential. There is some danger that clamping the appendix alone will not obliterate all its vessels and hemorrhage may result. Usually treatment with carbolic acid and alcohol are sufficient to prevent this. Always remove the appendix if possible and as early as possible after a diagnosis of appendicitis is made. In sewing up the wound use plain catgut for the peritoneum, chrome gut for the fascia and silkworm gut for the skin. If haste is necessary, use through and through silkworm gut. If there is much fat in the areolar tissue of the skin, make wide stitches, as the fat between the sutures will atrophy and the skin would otherwise pull out leaving a broad, unsightly scar.

Discussion.

Dr. Bonar. Why do you use silkworm gut in the skin?

Dr. O'Brien. For their strength and the fact that I believe they can be sterilized and do not become a culture medium for bacteria.

Dr. Briggs. Do you irrigate the peritoneal cavity with salt solution?

Dr. O'Brien. No, but I use normal salt enemata for stimulation and also because by so doing I find my patients suffer less from thirst.

Dr. Temple. Large sponges are used to protect the rest of the peritoneal cavity from contamination?

Dr. McAulay. We believe the introduction of large sponges irritates the peritoneum covering the bowels and adds to the shock, and also that it is not necessary if careful technic is employed in using sponges on sponge holders.

Adjourned to meet in Cloverdale in February.

JACKSON TEMPLE,
Secretary.

BOOK REVIEWS

Medical Gynecology. By S. W. Bandler, M. D. Publishers, W. B. Saunders Co. 1909.

The second edition of Dr. Bandler's text-book of Medical Gynecology appearing, as it does, so shortly after the first, one would hardly look for many changes—the only new feature being the introduction of Dr. Head's surface markings as an aid to diagnosis.

The author covers the subject in a very thorough manner, the chapters on Gonorrhea and Hydrotherapy in particular being well done. Repetitions however are far too numerous and the volume could be materially reduced, adding much to the comfort of the student. W. G. M.